Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Benlysta Order
(belimumab)

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis: _____

DX CODES: ***ICD-10*** : _____, _____, _____

Pregnancy Category C: Is an adequate form of birth control used: □ No □ Yes □ NA

Is Benlysta Gateway Authorization Form completed: □ Yes □ No □ **COPY ATTACHED**

LABS to be drawn: □ **CBC**
□ Other: _____

Pre- Medications:			
Diphenhydramine PO or IV	25mg or 50mg	□Yes	□ No
Cetirizine PO	10mg	□Yes	□ No
Acetaminophen PO	650mg	□Yes	□ No
Solu-Medrol IV	_____mg	□Yes	□ No

Start Date of Infusion: _____/_____/_____ **Benlysta Infusion #** _____

Benlysta IV Dosage:

□ 10 mg/kg □ Other: _____

□ every **4 wks**

□ **Initial dose- every 2 weeks for 3 doses then q 4 weeks**

IV over 60 mins @ 250ml/hr

Printed Provider's Name: _____

Provider's Signature: _____

Office Phone Number: _____**Office Fax Number:** _____